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1. Level I Nursing Facilities - These facilities provide skilled and intermediate nursing care continuously, but do not provide constant medical and support services available in an acute care facility or hospital. At least 60% of patients in these facilities receive skilled level of care services.

2. Level II Nursing Facilities - These facilities are often referred to as intermingled care and provide skilled and intermediate nursing care on a continuous basis. Skilled level of care services are provided for up to 60% of patients in these facilities.

3. Level III Nursing Facilities - These facilities provide health related care and services to individuals not requiring the degree of care and treatment provided by a hospital or to skilled care patients in a Level I or II facility. Level III facilities provide intermediate care prescribed by a physician to individuals who because of their mental or physical condition require institutional care and services.

4. Intermediate Care Facilities for the Mentally Retarded (ICF-MR) - These facilities provide care that parallels the care rendered by Level III facilities to patients that are mentally retarded.

d. Cost Center refers to one of five groupings of expenses reported on Schedule B-2 of the "Nursing Home Cost Report Under Title XIX," hereinafter referred to as the Cost Report. Specifically, expenses for the five cost centers are reported in Column 3 of the Schedule as Routine and Special Services (Lines 17 and 62), Dietary (Line 72), Laundry and Housekeeping and Operation and Maintenance of Plant (Lines 92 and 106), Administrative and General (Line 152), and Property and Related (Line 168). See hospital-based and state institutions cost reports for appropriate cost center expense groupings.

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e. Distinct Part Nursing Facilities are facilities in which a portion operates as a Level I or Level II nursing facility and another portion operates separately as an intermediate care facility for the mentally retarded.

f. Total Patient Days are the number of days reported by the facility on Schedule A, Line 13, Column 8 of the Cost Report subject to correction or adjustment by the Department for incorrectly reported data.

g. Hospital-Based Nursing Facilities - A nursing facility is hospital-based when the following conditions are met:

1) The facility is affiliated with an acute care hospital that is enrolled with the Department in the Hospital Services Program.

2) The facility is subordinate to the hospital and operated as a separate and distinct hospital department which has financial and managerial responsibilities equivalent to those of other revenue producing departments of the hospital.

3) The facility is operated with the hospital under common ownership and governance. The long-term care facility, as a department of the hospital, must be responsible to the hospital's governing board.

4) The facility is financially integrated with the hospital as evidenced by the utilization of the hospital's general and support services. A minimum of four services from Section A and two services from Section B below must be shared with the hospital.

Section A

a employee benefits
b) central services and supply
c) dietary
d) housekeeping
e) laundry and linen
f) maintenance and repairs

Section B

a) accounting
b) admissions
c) collections
d) data processing
e) maintenance of personnel

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Facilities must provide organizational evidence demonstrating that the above requirements of 4) have been met. This evidence will be used to determine which facilities will be hospital-based. Nursing

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facilities which were in existence prior to December 1, 1989, must have complied with the provisions of subsection 1002.1(g) by the aforementioned date or they will lose hospital-based status effective January 1, 1990.

Evidence that the required number of services in Sections A and B are shared with the hospital must be included in the hospital's Medicare cost report. Appropriate costs should be allocated to the nursing home and the Medicare cost report must be approved by the Medicare intermediary. This cost report compliance should occur at the earliest possible date subsequent to June 30, 1990.

In making the determination that a long-term care facility is hospital-based, collocation is not an essential factor; however, the distance between the facilities must be reasonable as determined by the Department or its agents.

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The Department will recover the monetary difference reimbursed to the facility between hospital-based and freestanding status for any time period the facility does not qualify for hospital-based status.

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To change classification to hospital-based from another class, or to enroll in the program as a hospital-based provider, effective July 1, 1994 and after, the following restrictions apply in addition to the requirements described above:

(A) Only one hospital-based nursing facility per hospital is allowed.

(B) Projections will not be allowed for existing facilities regrouped to the hospital-based classification. Any cost increases for the change to the hospital-based classification will be reimbursed when the first filed Medicare cost report is used to file the Medicaid cost report to set a per diem rate.

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Nursing facilities classified as hospital-based prior to July 1, 1994 will be exempt from the above additional requirements. Hospitals which currently have more than one hospital-based nursing facility will not be allowed to include any additional hospital-based facilities.

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h. Property Transaction is the sale[13,22] of a facility or of a provider; the lease of a facility; the expiration of a lease of a facility; the construction of a new facility; an addition to the physical plant of a facility; or any transaction, other than change of ownership of a provider due solely to acquisition of capital stock, or the merger of a provider with another legal entity (statutory merger).[12] The effective date of any Property Transaction shall be the latest of all of the following events which are applicable to the transaction:

1. The effective date of the sale or the lease.

2. The date the Department issues a rate to the State Health Planning Agency for its use in the Section 1122 review process.

3. The first day a patient resides in the facility.

4. The date of the written approval by the State Health Planning Agency of the relevant proposal.

5. The effective date of licensing by the Georgia Department of Human Resources Standards and Licensure Unit.

6. The effective date of the Statement of Participation in the Georgia Medical Assistance Program.

7. The date on which physical construction is certified complete by whichever agency(ies) is/are responsible for this determination.

8. The date of the approval of a Certificate of Need by the State Health Planning Agency.

i. Gross Square Footage is the outside measurement of everything under a roof which is heated and enclosed. When the Department

issues the provider a rate under the Dodge Index Property System, it is a tentative rate based upon the data previously submitted to the Department for verification. The data received on gross square footage and age of a facility are subject to audit review (along with other parameters which affect the billing rate calculation). Documentation should include but not be limited to blueprints, architect plans, certified appraisals, etc.

j. Age is the original date a building was completed counted by years through December, 1983 with no partial year calculations. For facilities with buildings constructed in different years, the composite age of the facility is computed using the number of square feet contained in each unit to produce a weighted average age.

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k. Cost is the expense incurred for goods and services used to operate a nursing facility. In the establishment of a per diem billing rate, most costs are allowable while certain other costs are not. A definition of cost and a discussion of allowable and nonallowable costs is contained in HCFA-15-1. In addition to those nonallowable costs discussed in HCFA-15-1, effective for the determination of reasonable costs used in the establishment of reimbursement rates effective on and after July 1, 1991, the costs listed below are nonallowable.

- Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;
- Memberships in civic organizations;
- Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

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- Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

- Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable.

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- Fifty percent (50%) of membership dues for national, state, and local associations;

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- Legal services for an administrative appeal or hearing, or court proceedings involving the provider and the Department or any other state agency when a judgement or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable;

- Advertising costs that are (a) for fundraising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement, or (e) related to government relations or lobbying.

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- Funds expended for personal purchases.

1002.2 Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate[1]

For these facilities the following formulas apply:

Total Allowed Per Diem Billing Rate =

Allowed Per Diem + Efficiency Per Diem +
Growth Allowance

Allowed Per Diem =

Summation of the (Net Per Diem or Standard Per Diem, whichever amount is less as to the facility)[2] for each of the four Non-Property Cost Centers plus the Net Per Diem for the Property and Related Cost Center.[3] Effective April 1, 1982, the Property and Related cost center reimbursement for those facilities whose cost reimbursement is limited to the standard (90th percentile) per diem in this cost center will be based upon the standard per diem calculated from the cost reports for the year ending June 30, 1981.

Efficiency Per Diem =

Summation of (Standard Per Diem minus Net Per Diem) x 75% up to the Maximum Efficiency Per Diem for each of the five cost centers.

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Growth Allowance =

Summation of 6.2% of the Allowed Per Diem for each of the four Non-Property and Related cost centers.

Further explanation of these terms is included below:

a. In general, the Net Per Diem[4] is determined from the costs of operation of the individual facility in which eligible patients reside. These reports are determined by utilizing the information submitted by the facility on its Cost Report.

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All amounts and supporting data submitted on the Cost Report are subject to verification and adjustment by the Department. These modifications concern: mathematical calculation errors; limitations placed on allowable costs by the Nursing Home Manual, and the documents, principles, and criteria referenced therein; reasonableness limitations placed on salaries paid employees of the facility;[24] reasonableness limitations using the principles contained in the Health Care Financing Administration Manual (HCFA-15-1);[5] or other parameters placed on reasonable cost by the Department.[23] These modifications basically concern what expenses are attributable to the care received and the reasonableness of the amounts of expenses which are attributable to care. See Appeals Section of this Manual for appellate procedures to resolve disputes of specific contested adjustments. Specifically, the Net Per Diem for each of the five cost centers is determined as follows (all Schedule references are to the Cost Report):

Routine and Special Services Net Per Diem[6] =

Rev. 7/1/95	Historical Routine and Special Services, Schedule B, Line 5 plus Line 6, plus Line 7, Column 4 Divided By Total Patient Days

Dietary Net Per Diem =

Historical Dietary, Schedule B, Line 8, Column 4, Divided By Total Patient Days

Laundry and Housekeeping and Operation and Maintenance of Plant Net Per Diem =

Historical Laundry, Housekeeping, Operation and Maintenance of Plant, Schedule B, Lines 9 plus 10, Column 4, Divided By Total Patient Days

Administrative and General Net Per Diem =

Historical Administrative and General, Schedule B, Line 11, Column 4, Divided By Total Patient Days

Property and Related Net Per Diem[7,21] =

Rev. 7/1/94	Historical Property & Related, Schedule B, Line 12, Column 4, Divided By Total Patient Days (which in no case shall be less than 85% of Schedule A, Line 17, Column 8)

The Return on Equity Percent is 0% for all facilities.

Rev. 7/1/95	Facilities reimbursed as of June 30, 1994 and June 30, 1995 for actual arm's length property and related costs will be reimbursed at the Dodge Index rate if a change in the audited reimbursement rate results in a per diem increase.

Rev. 7/1/94 Rev. 7/1/95	Facilities reimbursed as of June 30, 1994 and June 30, 1995 at actual arm's length property and related costs including those subject to standards, will not be reimbursed at the Dodge Index rate if a change in audited reimbursement results in a per diem decrease, unless a property transaction occurs as described in Section 1002.5(g) in which case the Dodge Index will apply. Until the Dodge Index applies to these facilities, reimbursement will continue at actual arm's length property and related costs.

Rev. 7/1/95	Facilities reimbursed for actual property and related costs will be reimbursed at the Dodge Index rate as described in Section 1002.5(g) through (l) below, if actual property and related costs per diem become less than the Dodge Index rate or if there is a property transaction according to Section 1002.5(g).

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Facilities reimbursed at the Dodge Index rate will remain at the Dodge Index rate for all subsequent periods.

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b. Standard Per Diem for each of the five cost centers is determined after facilities with like characteristics concerning a particular cost center are separated into distinct groups. Once a group has been defined for a particular cost center, facilities in a group[8,9] shall be ordered by position number from one to the number of facilities in the group, arranged by Net Per Diem from the lowest (Number "1") to the highest dollar value Net Per Diem. The number of facilities in the applicable group shall be

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multiplied by the Maximum Percentile, or a median net per diem may be chosen, with the Maximum Cost per day being determined as a percentage of the median. The Maximum Cost per day for the Administrative and General costs of all nursing facilities eligible for efficiency incentive payments is 105% of the median cost per day within each peer group. For those nursing facilities not eligible for efficiency incentive payments, the Maximum Percentile for Administrative and General costs is the seventieth percentile. The Maximum Percentile is the eighty-fifth

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for Laundry and Housekeeping and Operation and Maintenance of Plant cost centers. The Maximum Percentile is the ninetieth percentile for the Routine Services and Special Services, Dietary and the Property and Related cost centers. The method for

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determining the maximum allowable cost per day for nursing and dietary services for those nursing homes in a peer grouping of hospital based facilities will be modified. The current maximum allowable cost per day, set at the 90th percentile of costs for peer group members, will be reduced by 25% of the amount by which the 90th percentile amount for hospital based peer group exceeds the 90th percentile amount for peer groups of free-standing facilities. Such peer groups of free-standing facilities would not include any peer groups of skilled nursing facilities, intermediate care facilities for the mentally retarded or facilities with less than 50 beds.The resulting product shall be rounded to the closest whole number. If the resulting product falls exactly halfway between two whole numbers, the Standard Per Diem for that group shall be the mean of the Net Per Diems of the two facilities in the group which have position numbers equal to the two whole numbers between which the product lies. The standard Per Diem for a group shall be the Net Per Diem of that facility in the group which has the position number equal to the rounded product determined in accordance with the previous two sentences.

Routine and Special Services Standard Per Diem

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For this Standard Per Diem, all nursing facilities shall be grouped according to the mix of patients within the facility and freestanding versus hospital-based, as follows:[9,10]

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Level I Nursing Facility

Hospital-Based Nursing Facility with more than fifty beds

Distinct Part Nursing Facility with more than fifty beds

Level II Nursing Facility (Intermingled Care) with more than fifty beds

Level III Nursing Facility with more than fifty beds

Intermediate Care Facility for the Mentally Retarded

Level III Nursing Facility with fifty beds or less

Hospital-Based, Distinct Part, or Level II Nursing Facility (Intermingled Care) with fifty beds or less

Dietary Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped according to the mix of patients within the facility and freestanding versus hospital-based, as follows:

Level I Nursing Facility

Hospital-Based Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Level II, Level III, or Distinct Part Nursing Facility with fifty beds or less

Level II, Level III, or Distinct Part Nursing facility with fifty-one to one hundred beds

Level II, Level III, or Distinct Part Nursing Facility with more than one hundred beds

Laundry and Housekeeping and Operation and Maintenance of Plant Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped according to the mix of patients within the facility and freestanding versus hospital-based, as follows:

Level I, Level II, Level III, Hospital-Based, or Distinct Part Nursing Facility with fifty beds or less